State of California—Health and Human Services Agency
California Department of Public Health

MARK B HORTON, MD, MSPH
Director

ARNOLD SCHWARZENEGGER
Governor

March 10, 2009

Mr. Stan Oppegard, LFACHE
Deputy Secretary, Veterans Homes
Department of Veterans Affairs
P.O. Box 942895
Sacramento, CA 94295-0001

Dear Mr. Oppegard:

Please accept my apologies for the delay in responding to your letter, dated January 16, 2009, and also for the delay in responding to the Informal Dispute Resolution for the Veterans Home at Chula Vista. The final disposition of the Informal Dispute Resolution is that the facility's position is upheld and the deficiency in question, relating to the storage of emergency water, was deleted from the survey prior to it being uploaded into the Centers for Medical and Medicaid Services computer system. The facility can note the deletion on the facility's copy of the Statement of Deficiencies and Plan of Correction.

Again, please accept my apologies for the delay in responding.

Sincerely,

Robert G. Kennard, Chief
State Facilities Unit

cc: Lena Resurreccion, Supervisor
State Facilities Unit
Southern Regional Office
625 East Carnegie Drive, Suite 280
San Bernardino, CA 92408

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555795	A. BUILDING _____ B. WING _____	06/19/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VETERANS HOME OF CALIFORNIA -	700 EAST NAPLES COURT CHULA VISTA, CA 91911

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(x5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of California Department of Public Health during a Re-Certification survey. Representing California Department of Public Health: Manny Dumangas, HFIEN Aurora Calaguas, HFEN Margie Hillard, HIFEN Carolyn Johnson, HFIEN Mary Anne Hanthorn, Dietary Consultant Census:156 Resident Sample Size: 28	F 000		
F 170 SS=D	483.10(i)(1) MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the resident has the right to receive unopened mail. (Unsampled Resident 28) Findings: Resident 28 is an alert and oriented female, who was admitted to the facility on 4/25/08. The Minimum Data Set (MDS) done in 5/08 showed that the resident has no memory problems and independent with decision-making abilities. In an interview with Resident 28 conducted on	F 170	It is the policy of the Veterans Home to provide mail service to all residents in a manner that ensures confidentiality. Resident's personal mail will be delivered unopened, as addressed. On 6/17/08, the ADON counseled the OA (office assistant) about opening resident 28's mail and reviewed the Policy and Procedure on mail service with the employee. The Mail Delivery Policy and Procedures were revised and updated on 7/9/08 to include: 1) residents will receive assistance to open mail only with their written consent, and 2) residents handling other residents' mail are allowed to do so with a signed HIPAA/Mail Fraud Notification Form and a Volunteer Care Plan. Both forms have been added to our revised policy. All employees and volunteers of the Veterans Home that assist in mail delivery will be in-serviced on Wednesday, 7/16/08, on the updated policy. The social worker for unit 1100 spoke with resident 28 and apologized for our staff action and made the resident aware of our revised policy on mail service. The Standards Compliance Coordinator will do a random check every week using a monitoring tool and report any variances to the QA committee.	7/16/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (M) DATE

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F 170	Continued From page 1 6/17/08 at 2:30 p.m., she stated that she received an opened piece of mail about 2-3 weeks ago. She further stated that it was personal mail from the Veterans Administration (VA) that contained confidential information. She said that one of the residents delivers the mail in their unit, but she did not know who opened her mail. An interview was conducted with a licensed nursing staff on 6/17/08 at 2:45 p.m. She stated that she will inform the Social Worker about Resident 28's concern about this matter. During an interview with the office assistant staff from Unit 1100 conducted on 6/18/08 at 9:35 a.m., she stated that she opened the mail of Resident 28. She assumed it was a doctor's appointment and she was responsible for arranging the residents doctor's appointment. She further stated that the resident who volunteers to deliver the mail in the unit gave the letter to her. The office assistant staff stated that before she opened the resident's mail, she had requested a consent from the resident. A review of the facility's policy and procedure related to Mail Service indicated that "It is the policy of the facility to provide mail service to the residents of the SNF (Skilled Nursing Facility) in a manner that ensures confidentiality." The Mail Service procedure further indicated that: A. "All mail delivered by the U.S. Postal Service or by private carrier should be delivered to the front desk receptionist."... "The mail will then be delivered to the Mail Room and distributed unopened into the slots according to the address/ name on the envelope ..."	F 170		

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F 170	Continued From page 2 B."The SNF Unit Clerk will pick-up the mail from the mailroom and return to the unit. The Unit Clerk will distribute the mail to the corresponding resident immediately Monday through Friday." The facility failed to follow their policy and procedure related to Mail Service. The policy did not include that residents are allowed to distribute mails to the units. The policy did not include a procedure when a resident needed assistance to open her/his mails (ex. doctor's appointments) and did not address how this will be handled by staff. The facility failed to ensure that the resident was afforded her right to privacy, which included her right to receive unopened mail.	F 170		
F 226 SS=D	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that the policies and procedures on reporting all alleged violations and all substantiated incidents to the State agency and to all other agencies as required were implemented to one of three reported events reviewed. Findings: On 6/18/08 at 10:20 a.m., an interview with the Administrator was conducted. The Administrator was asked questions regarding investigations and	F 226	It is the policy of the Veterans Home to make an oral and/or written report to the appropriate authorities within 24 hours in any case where physical, financial or mental abuse is suspected. This includes suspected abuse committed in health care facilities as well as the resident's own environment. It is the responsibility of the individual suspecting the abuse to see that the reporting procedure is initiated. The SNF Administrator and the Supervising Registered Nurse involved in the 8/31/07 notification are no longer employed at the Veterans Home. The facility's policy for "Reporting Alleged or Suspected Elder Abuse" was reviewed and updated on 7/15/08. All Nursing staff will receive a mandatory in-service on the revised policy and procedures on 7/16/08. The Standards Compliance Coordinator will maintain a tracking log and monitor compliance with this policy. All variances will be reported to the QA committee.	7/16/08

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F 226	Continued From page 3 reporting of abuse. The Administrator stated, "Any injury is investigated and reported. We conduct nursing investigation and abuse is reported within 24 hours after occurrence." On 6/19/08 at 9:30 a.m., a review of an "Investigation Report" dated 9/5/07 was conducted. The report indicated an incident (altercation) involving two residents which occurred on 8/31/07. On the same date at 10 a.m., a review of the letter sent by the Skilled Nursing Facility (SNF) Administrator to the supervisor of California Department of Health Services (CDHS) dated 8/31/07 was conducted. The letter indicated, "I am writing to report an altercation between two residents [Resident A and Resident B] on September 5, 2007. If there is any additional information you require, please do not hesitate to call." The SNF Administrator's letter contained dates that were inaccurate. The incident occurred on 8/31/07 and not 9/5/07. The SNF Administrator could have inadvertently switched the date of the incident versus the date it was reported to CDHS. At any rate, the incident was not reported within 24 hours after it occurred. On the same date at 10- 1 5 a.m., a review of the Policy and Procedure (P&P) entitled "Incident Reporting" with a revision date of 2/9/05 was conducted. The P&P indicated, "D. All incidents of alleged or actual abuse, unexplained injuries, and unusual occurrences require initiation of an Investigation report and may need to be reported to the Department of Health Services within 24 hours."	F 226		

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F 241 SS=D	483,15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to maintain the dignity of residents by speaking in a language they did not understand, cleaning the dining area while residents are eating, diet change of a resident because his dentures were lost, not knocking on a resident's door before entering, and by not serving the requested food preference of an unsampled resident. Findings: 1. During the Resident Group Meeting on 6/1708 at 1 p.m., 10 of 18 residents complained that a foreign language was being spoken throughout the facility. The languages they said were being spoken are Tagalog and Spanish. The languages were being spoken in the presence of the residents, The residents stated that this has been an ongoing problem and has been brought up in several Resident Council Meetings and problem hasn't been resolved. An interview was conducted with nursing administrative staff on 6/18/08 at 2:35 p.m., who stated that this has been an ongoing problem and a very difficult one to deal with. 2. On 6/18/08 at 7:30 a.m., Unit 700- Pod 1 000 residents were observed seated at the table eating breakfast. The housekeeper began to	F 241	It is the Policy of the Veterans Home of California-Chula Vista to promote the care for residents in a manner and environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. 1. The Environmental Services Director met with all housekeeping staff on 6-20-08 regarding the requirement to speak in a language that residents understand while in a residential area. Mandatory in-servicing on Residents Rights was done on 7/8/08, 7/9/08; 7/10/08 for all staff. Supervisors will monitor their staff daily to ensure foreign languages are not spoken in resident care areas and will report variances to the QA committee quarterly. The Standards Compliance Coordinator will do a random check every week using a monitoring tool and report any variances to the QA committee. 2. The Environmental Services Director met with all housekeeping staff on 6/20/08 regarding cleaning in the pods while the residents were eating. He instructed staff to clean non-resident areas during mealtime. The schedule of the meal delivery times to the nursing units was posted in the housekeeping office for all housekeeping staff to review. The Standards Compliance Coordinator will do a random check every week using a monitoring tool and report any variances to the QA committee.	7/10/08 6/23/08

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F 241	Continued From page 5 clean the room, running the vacuum over the carpet, around the room and table until the surveyor intervened. The housekeeper failed to promote an environment that maintains each resident's dignity when she failed to postpone the vacuuming until the residents had completed their meal. 3. On 6/16/08 at 6:30 am, during the initial tour of the facility, it was observed that Resident 5, who required total staff assistance for all activities of daily living, was without lower dentures. An interview with the direct care staff, who was in the room at the time of the tour, revealed that she had "looked everywhere" but was unable to locate the resident's lower dentures. On 6/19/08 at 7-1 0 a.m., an interview was conducted with the Charge Nurse who reported that Resident 5's lower denture was never found. She further indicated that Resident 5's diet had been changed to a puree, and he would be referred to a dentist. However, the conversation at the nurses' station suggested that the facility did not have a referral dentist. The facility failed to care for Resident 5 in a manner that would enhance his dignity when they failed to maintain his dentures in a safe location. 4. During initial tour on Unit 1100 conducted on 6/16/08 at 6-15 a.m., a night shift nursing staff was observed entering the resident's room without knocking. Interview with a licensed nursing staff conducted on 6/19/08 at 1 0 a.m., revealed that nursing staff should always knock on the resident's door before entering at anytime of the day.	F 241	3. Resident 5's diet texture was modified and dental consult was done on 7/1/08 for new dentures. All residents with dentures will have their dentures maintained in a safe location at their bedside. The facility will ensure staff utilizes proper denture receptacles. All Nursing staff was in-serviced on Denture Care on 7/14/08, and 7/15/08. The Charge Nurses will do a random check every week using a monitoring tool and report variances to the QA committee. 4. Mandatory in-servicing on Residents Rights was done on 7/8/08, 7/9/08; 7/10/08 for all staff. Supervising nurses will perform a random check every week to make sure that staff is knocking at the residents' doors before entering the room and will report variances to the QA committee. The Standards Compliance Coordinator will do a random check every week using a monitoring tool and report any variances to the QA committee.	7/15/08 7/10/08

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F 241	Continued From page 6 5. During meal observation conducted on 6/16/08 at 12 noon, an unsampled resident was observed to be served with stuffed pork loin on her tray, which was left uneaten by the resident. The meal slip on her tray showed that the resident's dislikes included pork with gravy. In an interview with nursing staff conducted on 6/16/08 at 12:30 p.m., she stated that the resident requested an alternate item and was provided a fruit plate with yogurt. During interview with the resident conducted on 6/17/08 at 9 a.m., she stated she did not like eating pork because she knew that eating pork is not a healthy. A review of the resident's record indicated that pork was listed as one of her food dislikes. The Social History Evaluation dated 3/10/08, indicated that her religion was Seventh Day Adventist (a religion that prohibits eating pork).	F 241	It is the policy of the Veterans Home to honor the resident's food preferences, dislikes, ethnic/cultural background, and therapeutic needs. 5. The kitchen corrected the resident's food dislikes immediately and delivered an alternate of the resident's choice on 06/16/08. A current profile is maintained for each resident indicating diet order, likes, dislikes, allergies to foods, diagnosis and instructions of guidelines to be followed in the preparation and serving of food for the resident. The resident was re-interviewed by the Diet Technician on 07/01/08. Although the teachings of the Seventh-Day Adventists encourage the avoidance of pork & shellfish, the resident in question does not eat pork because of something that occurred when she was young. This was the same information that the resident told to the dietitian upon her admission. The resident continues to request a grilled ham and cheese sandwich on occasion and is aware that it is pork. There was a mandatory in-service for all staff on 07/08/08, 07/09/08 & 07/10/08 on Dignity. The Diet Technician and/or Registered Dietitian interview all residents upon admission, quarterly and whenever there is a concern to ensure compliance. The Director of Clinical Dietetics and Nutrition Services or designee will monitor compliance and report variances to the QA Committee.	7/10/08
F 253 SS=D	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the residents' refrigerator and other equipment were maintained in sanitary and orderly manner. Findings:			

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F 253	Continued From page 7 A tour of Unit 1100 was conducted on 6/19/08 at 10:35 a.m. The following were observed: 1. The resident's refrigerator located in the kitchenette was observed to have some sticky red stain marks on the bottom shelves. 2. There were two broken side boards found on the floor below the sink area. 3. There was a floor stain noted on the bottom of the sink. 4. There was a dirty commode, a chair that needed to be cleaned, a folded wheelchair and a broken concentrator that were lined up on the side of the hallway by the storage room and across the clean linen room. 5. A clean linen cart covered with plastic was noted to be observed placed in the same area in close proximity to the dirty items and other resident equipments that required repair or maintenance work. In an interview with the administrative licensed nursing staff conducted on the same date and time, she stated that the housekeeping staff were responsible for cleaning the residents' refrigerator, She further stated that a work order will be requested for the repair of the side boards. She did not know who placed the dirty items in the hallway and where the items came from.	F 253	It is the policy of the Veterans Home to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. 1. It is the policy of the Veterans Home that the residents' kitchenettes are to be cleaned by housekeeping staff twice daily on the day shift and upon notification of spills by the nursing staff. The refrigerators inside the kitchenettes are cleaned once daily and as needed. A cleaning log was created on 7/16/08 to document the refrigerator cleaning times. The Director of Environmental Services and the Procurement Officer will monitor this procedure monthly. The Standards Compliance Coordinator will do a random check every week using a monitoring tool and report any variances to the QA committee. 2. The broken sideboards were immediately repaired on 6/19/08. Staff is instructed to call Plant Operations for any needed repairs. The Standards Compliance Coordinator will do a random check every week using a monitoring tool and report any variances to the QA committee.	7/15/08 6/19/08
F 278 SS=D	483.20(g) — (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the		3. A cleaning log is now used to document the cleaning times. The floor stain cannot be removed. We will look to replace the floor upon approval of the FY 08/09 State Budget. The Director of Environmental Services and the Procurement Officer will monitor this procedure monthly. The Standards Compliance Coordinator will do a random check every week using a monitoring tool and report any variances to the QA committee.	7/15/08

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F 278	Continued From page 8 assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that residents' assessments accurately reflect the residents' weight, history of falls and pressure ulcer for 3 of 25 sampled residents (Residents 12, 4, and 13.) Findings: 1. Review of the record for Resident 12 indicated a 78 year old male, who was admitted to the facility on 12/01, with diagnoses that included osteoarthrosis, muscle weakness and depressive disorder. The resident is currently on Hospice Care for debility and comfort care. A review of the significant change Minimum Data		4. The items identified were immediately removed. A new equipment tag system will be instituted to prevent soiled, broken and miscellaneous equipment from accumulating in the hallways. The Health & Safety Committee will discuss this new system on Monday, July 21, 2008 and bring their ideas to the QA committee that will meet on July 23, 2008 to discuss and develop this new system. Policy and procedures will be approved on July 28, 2008 and in-services will be conducted for all staff involved in this new equipment tag system. The Standards Compliance Coordinator will do a random check every week using a monitoring tool and report any variances to the QA committee. 5. It is the Veterans Home policy to ensure that clean linen carts are not to be left in close proximity of any dirty items or dirty equipment. On 6/20/08 the Procurement Officer met with the Laundry Staff to instruct and educate them on this policy. This will be monitored by the Procurement Officer monthly to ensure compliance. The Standards Compliance Coordinator will do a random check every week using a monitoring tool and report any variances to the QA committee.	7/28/08 6/20/08

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 278	Continued From page 9 Set (MDS) dated 9/27/07, indicated that the resident's weight was recorded as 183 pounds (lbs.) The quarterly MDS dated 12/28/07 and 3/28/08 were reviewed. A review of the resident's Weekly/ Monthly Weight Record for 2007-2008 showed that the resident's weight was recorded at 167.6 lbs on 9/16/07. The MDS dated 9/07 did not accurately reflect the resident's weight. Further review of the weight record indicated that the resident's weight on 12/16/07 was recorded at 162. 6 lbs. On 3/8/08, the resident's weight was recorded as 139.8 lbs., a 22.8 lbs. significant weight loss, (14 % weight loss) within the past 90 days, and a 27.8 IDS weight loss, (16.5 % weight loss within the past 180 days), The resident's current quarterly IVIDS dated 3/08 did not reflect the above significant weight loss. Interview with the licensed nursing staff was conducted on 6/18/08 at 2*15 p.m. During the interview he revealed that the resident is due this month for a significant change of condition assessment, due to his weight loss and decline with his activities of daily living. The resident was placed on Hospice Care on 5/08 and did not want any measures aside from supportive care. In an interview with the Registered Dietician conducted on 6/19/08 at 9:05 a.m., she revealed that there was an error in the resident's weight on the 9/07 IVIDS. She stated there was an error for not indicating the resident's significant weight loss in the 3/08 IVIDS. She said that the resident had been identified as a nutritional risk and had been offered nutritional supplements since 12/07,	F 278	e It is the practice of the Veterans Home that an MDS Coordinator conducts and coordinates each resident's assessment and that the assessment accurately reflects the resident's status. Two new Full Time MDS nurses have been identified and will be hired upon passage of the FY 08/09 State Budget. 1. The staff that failed to accurately record the weight was educated by the supervisor on the MDS guidelines. Section K of the MDS will be reviewed on all current residents with weight loss. The RD's developed a tool to monitor all weight loss to ensure that the data is entered correctly in the MDS. Variances will be reported to the QA committee quarterly. 2. Resident 13 had a necrotic ulcer on the right foot. The ulcer was documented by MD as an ischemic ulcer due to a peripheral arterial disease. Per MDS guidelines, an ulcer of any type could be staged in section M1 of the MDS, which was done, but M2 was not coded because it was not a pressure ulcer. The skin assessment sheet and the treatment record were done on resident 13 until 12/07. In January 2008, a podiatrist saw the resident and the necrotic area on the right foot was resected and the necrotic ulcer was removed. Therefore, no ulcer was documented on the MDS assessment done on 3/28/08. On April 25, 2008, the staff noticed cyanosis with gangrenous	6/19/08

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIERICLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555795	A. BUILDING _____ B. WING _____	06/19/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VETERANS HOME OF CALIFORNIA -	700 EAST NAPLES COURT CHULA VISTA, CA 91911

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX F 278	PROVIDER's PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 10 which were discontinued due to the resident's refusal. 2. The record for Sampled Resident 13 was reviewed on 6/16/08. The resident was admitted to the facility on 3/15/07, with diagnoses that include Coronary Artery Disease, Cerebrovascular Accident, Dementia, Anxiety Disorder, Arthritis, and Osteoporosis. The MDS dated 3/28/08, showed that the resident was free of pressure ulcers, the previous MDS dated 12/29/07, indicated that the resident had a Stage 4 pressure ulcer. The record did not contain weekly assessments or a treatment sheet for this An interview was conducted with nursing staff on 6/17/08 at 3:30 p.m., who stated, "In September it was not assessed as a pressure sore, we sent her out for a Vascular Study, there was nothing done for her, the MD thought it was ischernic on her nail bed. That was why we did not code it as a pressure ulcer. In December it became necrotic (Black in color). At that time I coded it as a Stage 4 pressure ulcer." She also stated that it was never a pressure ulcer and that she should not have coded it on the MDS as one, it was a mistake. 3. The record for Sample Resident 4 was reviewed on 6/18/08. The resident was admitted to the facility on 8/5/02, with diagnosed that include Diabetes Mellitus 11, Hypertension, Dementia with Delusions, and Depression. The MDS dated 5/17/08 had no falls addressed, yet the record contained a Special Review for status/post fall dated 2/23/08.	F 278	tissue on the second digit of the right foot. The podiatrist saw Resident 13 on April 30, 2008. Staff will continue to use the skin assessment sheet for pressure and non-pressure sores as per the Home's Policy and Procedure. MDS Coordinator will attend the monthly skin and nutrition at risk committee meeting. The MDS nurse in the Quarterly IDT note will document any change in condition. 3. The Director of Nursing spoke with the MDS Coordinator about inaccurate and missing data on the Minimum Data Set. The MDS Coordinator was instructed on July 1, 2008 to attend the stand up meeting every morning and attend all special care conferences on falls. A monitoring log was developed by the MDS coordinator on falls and will be checked every month by the SRN's. Variances will be reported to the QA committee quarterly. All MDS entries on residents with incidence of fall in the last 3 months were reviewed by the MDS Coordinator to ensure accuracies of data entry. All MDS's will be reviewed consistently by the IDT in each care planning conference before locking the data and transmitting to CMS.	7/1/08

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F 278	Continued From page 11 An interview was conducted on 6/18/08 at 2 p.m., who stated after reviewing the record, "Yes, he did have a fall on 2/23/08. 1 don't know how, but I just missed it, so the MDS is not accurate." 483.25 QUALITY OF CARE			
F 309 SS=E	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure that they provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care by developing a policy and procedure on Vascular Catheter Access to one of twenty eight sampled residents (22) who is receiving hemodialysis services. Findings: On 6/18/08 at 4 p.m., an observation of Resident 22 was conducted. Resident was observed in room 1408-2 in his bed. Further observation revealed a vascular catheter access used for hemodialysis (a treatment that cleanse the blood by removing waste and excess water from the body when kidneys are in renal failure) located on the upper right chest of Resident 22. The	F 309	It is the policy of the Veterans Home to provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial wellbeing in accordance with the comprehensive assessment and plan of care. A mandatory in-service for nursing staff was conducted on 6/9/08, 6/10/08, and 6/11/08 by the Director of Nursing on Dialysis care that included care of vascular access sites. The policy on dialysis care was revised on July 2, 2008. Mandatory in-service for nursing staff was conducted on July 14, 2008 on the revision of the Dialysis care policy. Resident 22's care plan #10 regarding dialysis care was recopied and revised to include routine vascular catheter care. The dialysis care plan of all residents with vascular access sites were all checked to ensure that they include routine care of the vascular access sites. SRN's/MDS coordinator will monitor all residents with vascular catheter access sites to ensure compliance and report variances to the QA committee quarterly.	7/14/08

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F 309	Continued From page 12 vascular catheter was observed without any drainage, redness, and dry clean dressing. On the same date at 5:30 p.m., a review of Resident 22's clinical record was conducted. The review indicated that Resident 22 is a 57 year old male who was admitted in the facility -on 6/12/08 with diagnosis of End Stage Renal disease (ESRD). The record further indicated that Resident 22 currently receives hemodialysis through a vascular catheter three times a week. On 6/19/08 at I 0 a.m., an interview with the Assistant Director of Nursing (ADON) was conducted. The ADON was asked if there's any policy and procedure (P&P) for vascular catheter that will provide instructions to direct care staff on how to care, identify signs and symptoms of infection, and deal with emergencies such as bleeding to residents who have vascular catheter access. The ADON stated, "We don't have vascular catheter care P&P, but we will add it in the future. We incorporated the vascular catheter care with the hemodialysis care training." On the same date at 10:40 a.m., an interview with the Director of Staff Development (DSD) was conducted. The DSD stated, "There was no P&P on vascular catheter, we only have P&P on shunts (a passage between two blood vessels and access for hemodialysis)." The DSD further stated, "We will review our P&P on Dialysis Care and we will include the vascular catheter care." On the same date at 11, 1 5 a.m., an interview with the Charge Nurse was conducted. The Charge Nurse was asked if there was a P&P for vascular catheter that will provide instructions to direct care staff on how to care for Resident 22 who is	F 309		

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F 309	Continued From page 13 receiving dialysis services and has a vascular catheter access. The Charge Nurse stated that she's not sure if there's a P&P on vascular catheter in the unit. The Charge Nurse was also asked on how they provide care for Resident 22. She stated that they develop a care plan for the resident. The care plan is what they follow to provide care for the resident. However, the Charge Nurse stated, "Approaches and Interventions were crossed out. The vascular catheter care plan did not include a complete assessment of the vascular access site." On the same date at 11:25 a.m., a review of the facility's Policy and Procedure (P&P) entitled "Dialysis Care" was conducted. The review indicated that the P&P was developed only for residents receiving dialysis through a shunt. The record further indicated that there was no information found in the P&P that will provide instructions to direct care staff on how to care, identify signs and symptoms of infection, and deal with emergencies such as bleeding to residents who are receiving dialysis care and has a vascular catheter access.	F 309		
F 364 SS=E	483,35(d)(l)-(2) FOOD Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that prepared food was attractive, palatable, and nutritious. By not			

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F 364	Continued From page 14 ensuring that food was appealing and nutritious, there was the potential for diminished intake and residents not meeting nutritional needs. Findings: 1. On 6/17/08 between 7:46 a.m. and 7:50 a.m. at the main kitchen tray line there were breakfast foods which were not appealing and potentially unpalatable. In one half-filled insert pan at the steam table, one third of the bacon strips were charred and in another partially filled insert pan, link sausage was at 1 14 degrees F rather than the minimum distribution temperature of 140 degrees F before being tossed together to achieve a temperature of 147 degrees F. At 7:46 a.m. a dietetic service staff member stated that she had cooked the **bacon** at 5 a.m. and that the "burnt bacon" was likely a result of having held "the top layer so long." At 7:47 a.m. Dietetic Service Manager 1 stated that the sausage may have been "cooked early too, or maybe this batch had cooled" during service as it was more than half-depleted. Additionally, Dietetic Service Manager 1 stated that the dietetic service staff member had not been provided a production schedule for breakfast foods, 2. On 6/17/08 at 8:52 a.m. at the cafeteria servery hot food service line there was a partially filled insert pan of link sausage which was at 119 degrees F rather than the minimum distribution temperature of 140 degrees F before being tossed together and found to be at 158 degrees F. At 8:52 a.m. Dietetic Service Manager 1 stated that this batch of sausage may have been prepared by 5 a.m. and held under an uncertain temperature since cooking. The manager further stated that there was no production schedule for	F 364	It is the policy of the Veterans Home to provide food prepared by methods that conserve nutritive value, flavor, and appearance so that the food is palatable, attractive and at the proper temperature. 1, 2 & 3. Hot foods are made in small batches to eliminate holding periods. The cooks prepare and cook only as much bacon, sausage, soup and potatoes for the main kitchen tray line as will be used or served in a short period of time. Food items are not put into the steam table until 15 minutes before meal service time and held for less than 1 hour during the tray-line process. The bacon and sausage are stirred at regular intervals to distribute heat evenly. The internal food temperatures are checked every hour and recorded on a temperature log. The Diet Technician produces a daily production schedule from the GeriMenu program to be used by the Production Manager and Cooks for each meal. This includes a detailed list of food items to be produced for the current day's menu plus any advance preparation. This is used in conjunction with the quantified recipes and a production board. A mandatory in-service was conducted for all Food Service Workers on Food Preparation, Service and Daily Production Worksheets on 07/10/08. A Dietetic Service Manager or designee will monitor the batch cooking and production schedules daily. A Food Committee Meeting is held on the 1st Thursday of every month where residents have the opportunity to meet with the Dietary Staff and offer	7/10/08

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F 364	Continued From page 15 any prepared breakfast foods. 3. On 6/17/08 at 9:38 a.m. in the main kitchen hot food preparation area there was a large kettle filled with cream of mushroom soup which had a thick filmy layer on top. At 9:38 a.m. a dietetic service staff member stated that the soup was for lunch and she had prepared it "a half hour ago." She stated that some residents could receive the soup throughout lunch service which for some meant, "up to one-thirty (1:30 p.m.)" Upon identification of the thick film, the dietetic service staff member attempted to stir the soup, but the film only broke into more than twenty small clumps. Additionally, at 9:50 a.m. there was a batch of baked new potatoes (a vitamin C rich food) which was held for lunch service. At 9:50 a.m. Dietetic Service Manager 3 who checked with the same dietetic service staff member, stated that this batch had been thoroughly cooked half an hour earlier. According to Dietetic Service Manager 2 these potatoes had to cook for only 45 minutes and that they would be available for service pick-up and for the servery by 10:40 a.m. Dietetic Service Manager 1 also stated that the earliest any resident might receive the potatoes "would be eleven (1 I a.m.)" and that this would mean that the potatoes would have been cooked and held for a total of one hour and forty minutes by then. Further, Dietetic Service Manager I stated upon checking with both Dietetic Service Manager 3 and the dietetic service staff member, the other batches of potatoes would have combined cooking and holding times of two hours. At 9:55 a.m. Dietetic Service Manager 1 upon confirmation with Dietetic Service Manager 3	F 364	suggestions for improvement and menu changes. A Food Satisfaction Survey is conducted annually for all residents to provide feedback to the Dietary Staff. The Director of Clinical Dietetics and Nutritional Services attends the monthly Resident Council Meeting to answer resident questions and take suggestions. Comment Cards are always available in the Cafeteria, which are reviewed by the Dietary Staff regularly. The Director of Clinical Dietetics and Nutrition Services will monitor compliance during the monthly kitchen inspections and report variances to the QA Committee quarterly.	

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F 364	Continued From page 16 stated that there had not been a lunch production schedule to ensure that foods would not be overcooked and held excessively long. She said that "we could do this (have a production schedule) to be sure that the soup doesn't clump and the potatoes don't dry out."	F371	It is the policy of the Veterans Home to store, prepare, distribute and serve food under sanitary conditions. 1. A mandatory in-service was conducted for all Food Service Workers on Food Handling Procedures (HACCP Guidelines) & Food Temperatures and Storage (HACCP Guidelines) on 07/08/08 and on Infection Control, Food Safety and Sanitation on 07/09/08.	7/9/08
F 371 SS=F	483,35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and document review the facility failed to store, prepare, distribute and serve food under sanitary conditions. By having an unsanitary food service there was potential for cross-contamination and food borne illness. Findings: 1. On 6/17/08 between 7:30 a,m. and 7:45 a.m. there were unsanitary conditions in dry storage. a. At 7:30 a.m. there was a tub of chocolate icing with the lid hand-dated 6/16/08 which felt oily and which had dabs of icing on the exterior. At 7:30 a, m. Dietetic Service Manager 3 stated that the tub had been hand-dated to signify when opened. Dietetic Service Manager 3 also stated that he thought that the icing could be kept for six months or maybe, only for 30 days." On the label it stated that the icing could be kept for only 7-14 days if unrefrigerated. Dietetic Service		1a. All products, once opened, must be stored in clean, airtight containers with ingredient name and expiration date clearly labeled. The Dietetic Service Staff Member was immediately instructed on 06/16/08 about proper food storage, label and dating procedures. A mandatory in-service was conducted for all Food Service Workers on Food Handling Procedures & Food Temperatures and Storage on 07/08/08. A Dietetic Service Manager or designee shall oversee the procedures to ensure compliance. The Director of Clinical Dietetics and Nutrition Services will perform random checks as well as an in depth monthly kitchen inspection and report variances to the QA Committee. 1b. All dented cans are immediately placed in a designated labeled area for pick up by the food vendor. A mandatory in-service was conducted for all Food Service Workers on Food Handling Procedures (HACCP Guidelines) & Food Temperatures and Storage (HACCP Guidelines) on 07/08/08. A Dietetic Service Manager or designee shall oversee the procedures to	7/8/08 6/17/08

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F 371	Continued From page 17 Manager 3 had no explanation for why dietetic service staff had not ensured that the exterior of the tub had been clean prior to shelving. b. At 7:35 a.m. on a shelf in dry storage, there were two cans which had top lids coated with a white powder of uncertain origin. On another shelf there was a can of Hoison sauce with a dent on the top rim. At 7:35 a.m. Dietetic Service Manager 3 stated that the canned goods had been inspected during stocking and that "these items shouldn't be here." Also, on 6/17/08 at 10:25 a.m., upon return to dry storage, there was a #1 0 can of tropical fruit with a rim dent that had been shelved in the interim. c, At 7:45 a.m. within the dry storage room there were pipes for roof drainage, overflow and auxiliary purposes. One of pipes was above containers of juice and assorted beverages and another was above boxes of cereal, packages of condiments and canned goods. At 7:45 a.m. Dietetic Service Manager 3 stated that he did not know why these foods had been stored beneath pipes that might potentially break and leak during a disaster. Further, he stated that did not know why additional food supplies, inclusive of those for emergency/disaster meal service had been stored in this room. 2. On 6/17/08 between 7:46 a.m. and 8 a.m. there were potentially unsafe conditions at the main kitchen breakfast trayline. a. At 7:46 a.m. there was an insert pan loosely filled with link sausage which at were at 114 degrees F rather than the minimum safe holding temperature of 140 degrees F. Although the links were subsequently tossed together and found to	F 371 F 371	ensure compliance. The Director of Clinical Dietetics and Nutrition Services will perform random checks as well as an in depth monthly kitchen inspection and report variances to the QA Committee. 1c.The dry storage room was designated for the storage of dry goods and was licensed and certified as new construction on 9/17/97 by the Office of Statewide Health Planning & Development (OSHPD). The guidelines state that all facilities shall maintain in operating condition all buildings, fixtures, and spaces in the numbers and type as specified in the construction requirements under which the facility or unit was first licensed. The Veterans Home was licensed with the drains in the dry storage room. The roof drain & overflow drain are gravity drainpipes that are never under pressure and would only have water in them while it is raining. Without these drains there would be an increased possibility of excessive weight on the roof leading to a roof collapse. The focus of protection for dry storage is to keep non-refrigerated foods, disposable dishware, and napkins in a clean, dry area, which is free from contaminants. All packaged food, canned foods, and food items are stored are kept clean and dry at all times. All food, paper, and equipment items are stored on shelves $\geq$ 6 inches off the floor and $\geq$ 18 inches from the ceiling or light fixtures.	

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F 371	Continued From page 18 be at 147 degrees F, there was uncertainty on the part of Dietetic Service Manager I as to how long some of the sausage may have been below safe temperature although a cook reported that breakfast meats had been cooked by 5 a.m. and then "held" either in an oven or steam table. As of 7:46 a.m. although there was no documentation for cooking temperature of the sausage, no record of interim temperatures and uncertainty as to the duration of time held below 140 degrees F, there was no direction to remove the sausage for either re-heating to at least 165 degrees F or discard. At 7:48 a.m. Dietetic Service Manager 1 stated that continued service from tray line based on the appearance of the sausage which "looked done" might be okay, but that "maybe it should be pulled" (from service). Additionally, on 6/18/08 at 9 a.m. Dietetic Service Manager I presented a temperature log for meals served on 6/17/08. There was no entry for the temperature of sausage. b. At 8 a.m. in a reach-in refrigeration unit there were individual containers of cottage cheese which were at 49 degrees F, eight degrees above the maximum for safe service of chilled potentially hazardous foods. At 8 a.m. Dietetic Service Manager 1 stated that upon discussion with a dietetic service staff member she knew that the cottage cheese had been set-up in the unit since 5:30 a.m. and that it would "have to be discarded" due to the uncertainty as to the temperature of the cottage cheese when first placed in the unit and when residents might actually consume it. 3. On 6/17/08 between 8:15 a.m. and 8:50 a.m. in the cafeteria servery there were unsanitary,	F 371	2a. Foods shall be stirred regularly to provide for even temperatures. All potentially hazardous foods shall be kept out of the temperature danger zone at all times, except during necessary periods of preparation and service. A total of 4 hours is the maximum time food may be in the danger zone for the flow of food cycle. The temperature of the sausage was 159 degrees before being placed on the tray-line. The staff member who did not take the temperatures on tray line was verbally counseled 06/18/08 on taking the temperatures of all items that are served. All hot foods with temperature below the standard shall be reheated to 165 degrees for 15 seconds or discarded. A mandatory in-service was conducted for all Food Service Workers on Infection Control, Food Safety and Sanitation on 07/09/08. The Diet Technician or designee will monitor the temperature logs daily. The temperature logs are included in the QA monitoring program. The Director of Clinical Dietetics and Nutrition Services will monitor compliance and report variances to the QA Committee. 2b. A mandatory in-service was conducted for all Food Service Workers on Infection Control, Food Safety and Sanitation on 07/09/08. All food and beverages are served at the appropriate temperatures. The temperatures of all meal items are monitored and recorded daily. All cold items are placed in the freezer at least an hour before meals. The temperature logs are included in the	7/9/08 7/9/08

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F 371	Continued From page 19 unsafe conditions. a. At 8-15 a.m. in a self-service refrigeration unit which had an internal thermometer which registered 45 degrees F, foods and beverages were stored compactly and at temperatures above 41 degrees F, the maximum for the safe service of potentially hazardous foods. Milk was at 46-47 degrees F and yogurt was at 46 degrees F. At 8-19 a.m. Dietetic Service Manager 1 attributed the elevation in food and beverage temperatures to the frequency of residents accessing items, especially "around eight (8 a.m.)" and the fact that the adjacent unit had malfunctioned "last night" which resulted in compact storage as what would have normally been in two units, was now in one. Dietetic Service Manager 1 also stated that the dairy items would "have to be chilled in ice now" as they were above 41 degrees F for uncertain duration and "might continue to warm-up" otherwise. Dietetic Service Manager 1 stated that she did not have a record of the temperatures of the foods under refrigeration and doubted that dietetic service staff had been checking the unit. b. At 8:20 a.m. in a reach-in dessert freezer containing ice cream and sherbet there were eight containers of raspberry sherbet, which had frozen red stains on the exteriors of the lids. Although the contents upon inspection appeared frozen even when the internal thermometer of the freezer registered 22 degrees F rather than 0 degrees F or below to ensure safe chilling, Dietetic Service Managers 1 and 3 chose to retain the sherbet and attributed the stains to either prior leakage from a container and/or an intermittent temperature elevation.	F 371	QA monitoring program. The Director of Clinical Dietetics and Nutrition Services will monitor compliance and report variances to the QA Committee. 3a. The Plant Operations department was notified of the broken refrigerator immediately. The internal thermometers in the servery refrigerators are checked twice a day and logged. All internal thermometers were checked for accuracy and replaced on 06/21/08. A mandatory in-service was conducted for all Food Service Workers on Food Handling Procedures (HACCP Guidelines) & Food Temperatures and Storage (HACCP Guidelines) on 07/08/08. A Dietetic Manager or designee will check the temperatures of the cold items in the servery refrigerators with a calibrated thermometer at least weekly. The temperature logs will be included in the QA monitoring. The Director of Clinical Dietetics and Nutrition Services will monitor compliance and report variances to the QA Committee. 3b. It is the responsibility of the facility's Food Service department to notify the Plant Operations department of any new equipment. The temperatures in all of the freezers are checked twice a day and logged. All potential unsafe sherbet was thrown out immediately. A mandatory in-service was conducted for all Food Service Workers on Food Handling Procedures (HACCP Guidelines) & Food Temperatures and Storage (HACCP Guidelines) on 07/08/08. A Dietetic Manager or designee will check the temperature of the frozen items in the reach in freezers on a regular	7/8/08 7/8/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555795	A. BUILDING _____ B. WING _____	06/19/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VETERANS HOME OF CALIFORNIA -	700 EAST NAPLES COURT CHULA VISTA, CA 91911

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER's PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 20 Subsequently, at 8:50 a.m. after reconciling the lack of temperature maintenance in a kitchen reach-in freezer which had been used to store the ice cream and sherbet prior to stocking in the cafeteria servery reach-in freezer and finding that the internal thermometer of the reach-in freezer in the servery now registered minus 2 degrees F and that the raspberry sherbet was at minus 5 degrees F and strawberry ice cream at 0 degrees F, discussion ensued with Dietetic Service Managers 1, 2 and 3. At 8:50 a.m. Dietetic Service Managers 1 and 2 stated that the contents of what had been stored in the kitchen reach-in freezer, which had not maintained temperature as well as what was in the servery would have to be discarded. Dietetic Service Manager 2 added that the reach-in freezer in the kitchen "would be looked into" because it could have contributed to potentially unsafe service of items that were to have been maintained frozen. c. At 8:52 a.m. at the hot food service line there was an insert pan loosely filled with link sausage which were at 119 degrees F rather than the minimum for safe holding temperature of 140 degrees F At 8:52 a.m. although the links were subsequently tossed together and found to be at 158 degrees F, Dietetic Service Manager 1 stated that it was possible that this batch of sausage had been prepared by 5 a.m. and held under an uncertain temperature since cooking. Dietetic Service Manager 1 also stated that even though The sausage looked cooked, that "the more time it is out" and being depleted, "the greater the opportunity for cooling" and of concern, given that residents could be served these foods and eat them "around nine (9am)". The uncertainty as to the cooking and holding temperatures with the potential to keep the sausage for four hours	F 371	basis with a calibrated thermometer. The temperature logs will be included in the QA monitoring program. The Director of Clinical Dietetics and Nutrition Services will monitor compliance and report variances to the QA Committee. 3c. Foods shall be stirred regularly to provide for even temperatures. All potentially hazardous foods shall be kept out of the temperature danger zone at all times, except during necessary periods of preparation and service. A total of 4 hours is the maximum time food may be in the danger zone for the flow of food cycle. The temperature of the sausage was 159 degrees F before being placed on the tray-line. The staff member who did not take the temperatures of the sausage on tray line was verbally counseled 06/18/08 about taking the temperatures of all items that are served. The cafeteria hot items have their own temperature logs. The temperatures of the sausage links were 156 degrees the first hour and 140 degrees on the second hour. All meal services last < 2 hours. All hot foods with temperature below the standard shall be reheated to 165 degrees for 15 seconds or discarded. A mandatory in-service was conducted for all Food Service Workers on Infection Control, Food Safety and Sanitation on 07/09/08. The Diet Technician or designee will monitor the temperature logs daily. The temperature logs are included in the QA monitoring program. The Director of Clinical Dietetics and Nutrition Services will monitor compliance and report variances to the QA Committee.	7/9/08

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F 371	Continued From page 21 increased the likelihood for the growth of microorganisms and toxin development. On 6/18/08 at 9 a.m. Dietetic Service Manager I presented the temperature log for the meals served on 6/17/08. She stated that as far as she knew, the food temperatures had been taken in the main kitchen at tray line. Review of the log revealed that there was no delineation to show if food temperatures were from the main kitchen or cafeteria servery and that data was missing for dinner. Also, while records seemed fairly complete for breakfast and lunch, there was no documented temperature for sausage. 4. On 6/17/08 between 8:21 a.m. and 9:16 a.m. there were unsanitary, potentially unsafe conditions in three main kitchen refrigerators and the ice machine. a. At 8:21 a.m. there was a reach-in refrigerator containing liquid supplements which had dirty gaskets. At 8:21 a.m. Dietetic Service Manager 1 stated, I think we should get this cleaned." b. At 8:37 a.m. there was a walk-in refrigerator which had an uncovered crate of containers of Ricotta cheese (which is similar to cottage cheese) that had black matter of uncertain origin on the lids and shredded off-white matter on the shelving next to them. At 8:37 a.m. Dietetic Service Manager 2 stated that he thought that the black matter may have been the result the stacking process and that the shredded matter was "probably Parmesan cheese." Although uncertain as to the origins of both, there were no attempts on the part of Dietetic Service Manager 2 to remove or clean the containers of Ricotta cheese and clean the shelving.	F 371	4a. The dirty gasket in the reach-in refrigerator was cleaned immediately. The reach-in refrigerators are cleaned each week and more often as needed. A Dietetic Service Manager or designee shall oversee the procedures to ensure compliance. The Director of Clinical Dietetics and Nutrition Services will perform random checks as well as an in depth monthly kitchen inspection and report variances to the QA Committee. 4b. The Ricotta Cheese containers, crates and shelving were cleaned on 06/17/08. The Dietetic Staff Member was instructed to clean all dirty items immediately upon delivery and when ever necessary. A mandatory in-service was conducted for all Food Service Workers on Food Handling Procedures (HACCP Guidelines) & Food Temperatures and Storage (HACCP Guidelines) on 07/08/08. A Dietetic Service Manager or designee shall oversee the procedures to ensure compliance. The Director of Clinical Dietetics and Nutrition Services will perform random checks as well as an in depth monthly kitchen inspection and report variances to the QA Committee.	6/17/08 7/808

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555795	A. BUILDING _____ B. WING _____	0611912008

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F 371	Continued From page 22 c. At 9:10 a.m. in a reach-in refrigerator there was an opened jug of fresh garlic cloves which had brown debris on the peels (per the label, a product from a foreign country). At 9:10 a.m. Dietetic Service Manager 1 stated that the garlic was from an approved vendor. In the absence of manufacturer's directions and/or vendor literature it was uncertain if this product had been cleaned and/or pre-treated so as to use it safely in the preparation of non-acidic foods, e.g. the facility's garlic oil. Without this assurance, there was the potential for the dangerous growth of anaerobic microorganisms. d. At 9:16 a.m. there was moist dark brown matter on the doorframe of the ice machine. At 9:16 a.m. Dietetic Service Manager 1 stated that she was surprised that it looked "so brown" as there was a policy for routine cleaning and sanitizing. 5. On 6/17/08 between 9-18 a.m. and 10:25 a.m. there were unsafe, cross-contaminating conditions in the main kitchen aisles, production areas and dish room. a. At 9-18 a.m. just above the 213A doorway which was an entry and egress to the outdoors, there was a ceiling fly fan box coated with dust. At 9-18 a,m. Dietetic Service Manager 2 stated, "It looks pretty thick and the dust might fall off ." Between 9-18 a.m. and 9:22 a.m. there were at least four flying insects near the cold food preparation area which was not in the immediate vicinity where the flies would have otherwise been trapped. b. At 9:23 a.m. near the cold food preparation	F 371	4c. Food specifications state produce shall be of good quality, USDA Inspected, Fancy to USDA #1.The peeled fancy garlic gloves were purchased from an approved vendor. The company was contacted immediately. Although the garlic was a product of China, it was packaged by Best Buy Products Int'l, INC. Los Angeles, CA. Moisture, lack of oxygen, low-acid conditions and room temperature all favor the growth of Clostrudium bootulinum. The garlic-in-oil mixture was kept under refrigeration and used within 2 days. The dietetic staff member was instructed not to make bulk garlic and oil mixtures. 4d. The ice machine bins and ice machine doorframes are cleaned and sanitized monthly or more often as needed. A mandatory in-service was conducted for all Food Service Workers on Infection Control, Food Safety and Sanitation on 07/09/08. A Dietetic Service Manager or designee shall oversee the procedures to ensure compliance. The Director of Clinical Dietetics and Nutrition Services will perform random checks as well as an in depth monthly kitchen inspection and report variances to the QA Committee. 5a. The Plant Operations staff was notified of the dust on the fly fan box 06/18/08. The fan was cleaned immediately. All maintenance concerns are reported to the Plant Operations staff and recorded for the Plant Operations department to address. The vents in the kitchen are cleaned on a regular basis by the Plant Operations. The facility has a preventative pest control program as	6/17/08 7/9/08 6/18/08

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555795	A. BUILDING _____ B. WING _____	06/19/2008

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F 371	Continued From page 23 area in addition to the storage of a cutting board which was soiled with food debris, there were five deeply scratched, stained cutting boards and two others which had deep scratches, Also, within twelve feet of this storage area there was a badly scratched cutting board which was used by a dietetic service staff member while cutting vegetables. At 9:23 a.m. Dietetic Service Managers I and 2 stated that they knew that the boards "are a problem" and that without a mechanical chopper or some alternatives they had to routinely use knives and that they had to '.constantly check" that they were kept sharp and the boards "good enough" for safe, effective slicing and chopping. c. At 9:37 a.m. near the hot food preparation area there was a preparation sink, which was filled with frozen fish that was soaking in near-still water which was cold to the touch and under a thin slow, stream of water from the faucet. The practice of not having brisk, continuously draining cold water for thawing could lead to a period in which food could be at or near room temperature and result in the growth of microorganisms and d. At 9:38 a.m. there was a brown roach which scampered across a floor mat in the hot food preparation area. At 9:38 a.m. Dietetic Service Manager 2 stated that he would "have to call the pest control service back" as "what they had just done looks like it may have not killed off the bugs." e. At 9:39 a.m. near the pot and pan set-up there were three plastic bins containing clean service utensils and support materials, which had stained adhesive labels with dates that were more	F 371	implemented by a reputable vendor. Records of any pest sightings are documented and kept on file for a period of one year. A Dietetic Service Manager or designee shall oversee the procedures to ensure compliance. The Director of Clinical Dietetics and Nutrition Services will perform random checks as well as an in depth monthly kitchen inspection and report variances to the QA Committee. 5b. All deeply scratched and stained cutting boards were thrown out immediately. The cutting boards are cleaned and sanitized after each use. All cutting boards with dark lines and staining are thrown out immediately. A Dietetic Service Manager will monitor the cutting boards on a weekly basis. The Director of Clinical Dietetics and Nutrition Services will monitor compliance and report variances to the QA Committee. 5c. The Dietetic Staff Member was verbally counseled on the proper thawing procedures on 06/17/08. A mandatory in-service was conducted for all Food Service Workers on Infection Control, Food Safety and Sanitation on 07/09/08. The Dietetic Service Manager/Chef or designee will monitor the thawing process each day. The Director of Clinical Dietetics and Nutrition Services will monitor compliance and report variances to the QA Committee.	6/17/08 7/9/08

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F 371	Continued From page 24 than two months old on them. At 9:39 a.m. Dietetic Service Manager 1 stated that the type of labels had been difficult to get removed via dishwashing and peeling and that "there probably needs to be a new type (of labels)." f. Between 9:40 a.m. and 10:04 a.m. in the aisles near cold food preparation and the hot beverage set-up area there were four empty synthetic carts which had stains of uncertain origin. At 9:40 a.m. two dietetic service staff members reported that the carts had not been used within the hour and one stated that three of the carts looked "clean." At 10:04 a.m. Dietetic Service Manager 1 stated that the carts were "old" and that while some of the black stains "might be from placing hot items on the carts" the source of the other stains which were brown and red was unknown. g. At 9:59 a.m. in the dish room on a shelf for clean items, there were eight semi-opaque plastic pitchers which had cloudy brown stains which had a strong tannic odor despite having been run-through the dish machine and dry. At 10-10 a.m. Dietetic Service Manager 1 stated that the pitches were old, still in use and probably had been used for iced tea prior to being washed, rinsed and sanitized h. At 10:25 a.m. in a walk-in refrigerator there was a shelf containing at least 5 lbs of thawing packaged pastrami immediately above a shelf containing an uncovered bin filled with more than twenty individual servings of prune juice. At 10:25 a.m. Dietetic Service Manager 2 stated that he «need(ed) to talk to staff' about this storage practice as it could be cross-contaminating in the event that there was a leak in the packaging and	F 371	5d. The Plant Operations staff was notified of the brown roach immediately on 06/18/08. The facility has a preventative pest control program as implemented by a reputable vendor. Records of any pest sightings are documented and kept of file for a period of one year. A Dietetic Service Manager or designee shall oversee the procedures to ensure compliance. The Director of Clinical Dietetics and Nutrition Services will perform random checks as well as an in depth monthly kitchen inspection and report variances to the QA Committee. 5e. The adhesive labels were removed immediately. A Dietetic Service Manager or designee shall oversee the cleaning and sanitizing of the kitchen. The Director of Clinical Dietetics and Nutrition Services will perform random checks as well as an in depth monthly kitchen inspection and report variances to the QA Committee. 5f. The stained and broken utility carts were disposed of immediately. A Dietetic Service Manager or designee shall oversee the equipment. The Director of Clinical Dietetics and Nutrition Services will perform random checks as well as an in depth monthly kitchen inspection and report variances to the QA Committee. 5g. The eight semi-opaque plastic pitchers were disposed of immediately. A Dietetic Service Manager or designee shall oversee the equipment. The Director of Clinical Dietetics and Nutrition Services will perform random checks as well as an in depth monthly kitchen inspection and report variances to the QA Committee.	6/18/08 6/17/08 6/17/08 6/17/08

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F 371	Continued From page 25 the meat juices dripped onto the containers of prune juice. Cross-Reference to F 456. 6. During initial tour conducted in the main kitchen on 6/16/08 at 6:20 a.m., a dietary staff was observed working without a hair net. When asked if he's supposed to be wearing a hairnet, he replied, "Yeah, sorry about that." The dietary staff then immediately dons a hair net. On 6/18/08 at 1 a.m., a review of the Policy and Procedure (P&P) entitled "infection Control, Food Safety and Sanitation" with a revision date of 7/27/06 was conducted. The review indicated, 'T CLINICAL DIETETICS AND NUTRITION SERVICES PERSONNEL, A. Clinical Dietetics and Nutrition Services Personnel shall practice safe and sanitary food handling techniques. 1. Clinical Dietetics and Nutrition Services personnel shall be trained in basic food sanitation techniques, wear clean clothing, and a cap or a hair net..." 7. During initial tour conducted in the main kitchen on 6/16/08 at 6:30 a.m., multiple food products that expired were observed in two different refrigerators (Refrigerator #3 and #4) as follows: A. Refrigerator #3 1. Yams in a metal container with a preparation date of 6/12/08 and expiration date of 6/14/08. 2. Ham in a metal container with a preparation date of 6/13/08 and expiration date of 6/15/08. 3. Chicken flavoring with an unknown preparation	F 371	5h. The dietetic staff member was immediately verbally counseled about the proper thawing procedures. A mandatory in-service was conducted for all Food Service Workers on Food Handling Procedures (HACCP Guidelines) & Food Temperatures and Storage (HACCP Guidelines) on 07/08/08. A Dietetic Service Manager or designee shall oversee the procedures to ensure compliance. The Director of Clinical Dietetics and Nutrition Services will perform random checks as well as an in depth monthly kitchen inspection and report variances to the QA Committee. 6. Clinical Dietetics and Nutrition Services personnel are trained in basic food sanitation techniques, wear clean clothing, and a cap or a hair net. It is the policy of the facility that hair coverings shall be worn in all food preparation and service areas. The dietetic staff member was new and had gone through orientation the previous week. The orientation information states, "a hair net shall be worn." The Dietetic Staff member was verbally counseled about wearing a hair covering at all times. A Dietetic Service Manager or designee shall oversee that all staff are wearing hair coverings at all times. The Director of Clinical Dietetics and Nutrition Services will perform random checks as well as an in depth monthly kitchen inspection and report variances to the QA Committee.	7/8/08 6/18/08

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F 371	Continued From page 26 date and an expiration date of 6/10/08. B. Refrigerator #4 1. Turkey in a metal pan with a preparation date of 6/12/08 and expiration date of 6/15/08 On the same date at 6:40 a.m., an interview with the dietary staff was conducted. The dietary staff was asked regarding the expired multiple food products that were observed in Refrigerator #3 and #4. The dietary staff stated, "They're expired and should have been discarded." On 6/18/08 at 1 a.m., a review of the Policy and Procedure (P&P) entitled "Infection Control, Food Safety and Sanitation" with a revision date of 7/27/06 was conducted. The review indicated, "VI, TIME FRAMES FOR FOOD STORAGE, 1. REFRIGERATED STORAGE, 2. Foods to be expired within 48 hours (2 days) after Prepared or Opened (... cooked leftover foods, opened canned fruit and vegetables ...), 3. Foods to be expired within 72 hours (3 days) after Prepared or Opened (Deli meats - sliced turkey, ham, roast beef)."	F 371	7. A&B. A mandatory in-service was conducted for all Food Service Workers on Food Handling Procedures (HACCP Guidelines) & Food Temperatures and Storage (HACCP Guidelines) on 07/08/08. The Infection Control, Food Safety and Sanitation in-service were given on 07/09/08. An expiration log was initiated. A dietetic staff member will be designated to throw out all expired food at the end of each day. The Dietetic Service Manager or designee will monitor the use and expiration of leftovers and extra food. The Director of Clinical Dietetics and Nutrition Services will perform random checks as well as an in depth monthly kitchen inspection and report variances to the QA Committee.	7/9/08
F 456 SS=E	483.70(c)(2) SPACE AND EQUIPMENT The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain all main kitchen equipment in safe operating condition. By not having maintained equipment there was potential 1 for insufficient surveillance of operations which	F 456	It is the Policy of the Veterans Home to maintain all essential mechanical, electrical and patient care equipment in safe operating condition. 1. The Plant Operations department was notified of the inoperable self-service reach-in refrigerator on 06/16/08. All cold items were transferred to the adjacent refrigerator. A sign was posted on the inoperable self-service reach-in refrigerator on 06/18/08. The maintenance staff ordered the compressor part. Estimated date of delivery is 7/31/08. The temperatures are logged twice a day. Cold item temperatures are taken each meal. It is the responsibility of the facility's Food Service department to notify the Plant Operations department of any equipment concerns. All equipment problems are	7/31/08

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F 456	Continued From page 27 could contribute to food borne illness and unappealing, unpalatable food. Findings: 1. On 6/17/08 between 8 a.m. and 8:20 a.m. in the cafeteria servery there was an inoperable self-service reach-in refrigerator. At 8,19 a.m. Dietetic Service Manager 1 reported that it had been taken out of use the previous evening, although there was no sign to such effect, At 8:20 a.m. she stated that as a consequence, the contents for breakfast service had been stocked with those typically held in the adjacent reach-in refrigerator "in the morning." On 6/18108 at 9 a.m. Dietetic Service Manager 2, Operations Staff 1 and Maintenance Staff 1 reported that this reach-in refrigerator had been problematic. Operations Staff 1 stated that there had been an on-going problem in getting the correct parts. Maintenance Staff 1 added that there might be a problem with the compressor and that "some temperatures were up-- above 41 degrees F since the fourth (6/4/08)." 2. On 6/17/08 between 8:37 a.m. and 8:50 a.m. in the main kitchen there was frozen condensation on the ceiling of a walk-in freezer. By 8:50 a.m. discussion ensued amongst Dietetic Service Manager 2, Operations Staff 1 and Maintenance Staff 1. Dietetic Service Manager 2 attributed some of the frozen condensation to times when dietetic service staff might open the door for stocking and freezing followed. However, there was a discrepancy in the reported defrost cycling frequency, timing and duration between Operations Staff 1 and Maintenance Staff 1 which may have explained practices which contributed	F 456	reported to the Plant Operations staff and recorded for the Plant Operations department to address. A mandatory in-service on Space and Equipment was conducted for Food Service and Plant Operation staff on 07/15/08. 2. The Plant Operations department coordinated the defrost cycling frequency, timing and duration with the Food Service department to allow for maximum efficiency with the peak operating hours. The times for defrosting the freezer will be reset with each seasonal time change by the Plant Operations department. The Dietetic Service Manager shall oversee the procedures and notify the Plant Operations department of any needed changes in the defrost cycle of the walk-in freezer. A mandatory in-service on Space and Equipment was conducted for Food Service and Plant Operations staff on 07/15/08.The Director of Clinical Dietetics and Nutrition Services will perform random checks as well as an in depth monthly kitchen inspection and report variances to the QA Committee.	7/15/08

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	555795	A. BUILDING _____ B. WING _____	06119/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VETERANS HOME OF CALIFORNIA -	700 EAST NAPLES COURT CHULA VISTA, CA 91911

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER's PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 456	Continued From page 28 to unexpected temperature elevations resulting in condensation formation on the ceiling with subsequent freezing. Operations Staff 1 initially stated that there were three times (1 a.m., 9 a.m., and 3 p.m.) for 15 minutes in a 24 hour period for defrosting while Maintenance Staff 1 stated that the "first defrost" was at 8 a.m. and that there were "four times about one hour, one hour and ten minutes each time" when defrosting occurred in a 24 hour period. Subsequently, Operations Staff 1 stated that "the correct, current defrosting occurs at 8 a.m., 2 p.m., 8 p.m. and 2 a.m. for one hour and ten minutes although it used to be at 9 a.m., 3 p.m., 9 p.m. and 3 a.m. for the same (duration)." Together, all three reported that the times for defrosting the freezer had not been reset for Spring and Fall and that as far as they knew, there had not been any coinciding times when dietetic service staff accessed and stocked the freezer. On 6/18/08 at 9:15 a.m. Dietetic Service Managers 1 and 2, Operations Staff I and Maintenance Staff I reported that the walk-in freezer had required resetting and correction such that it was to now defrost four times per 24 hour period for at least one hour and ten minutes each time. Both Operations Staff 1 and Maintenance Staff 1 also stated that they had not made adjustments in the Spring and Fall "for awhile" and that with the most recent resetting, they realized that for at least one of the prior defrost cycles that it would have occurred about an hour before the time when dietetic service staff may have been stocking or accessing the freezer. However, additional inspection of the walk-in freezer at 10 a.m. revealed that while the gauge	F 456		

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	555795	A. BUILDING _____ B. WING _____	06/19/2008

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F 456	Continued From page 29 registered minus 1 degrees *F* and the internal thermometer registered minus 8 degrees *F*, there was still the presence of frozen condensation on the ceiling. 3. On 6/17/08 at 8:50 a.m. in the main kitchen there was a reach-in freezer, which was stocked with sherbet and ice cream and from which some the items were now in a cafeteria servery reach-in freezer. In the latter it had been noted at 8:20 a.m. that eight individual containers of raspberry sherbet had apparently leaked, then re-froze. Inspection of the main kitchen reach-in freezer by Dietetic Service Manager 2 revealed that the thermostat had not been set correctly so as to ensure a minimum safe storage temperature of at least 0 degrees F. Further inspection of the main kitchen reach-in freezer revealed that the orange sherbet was at 5 degrees and raspberry sherbet was at 1 degrees F. At 8:50 a.m. due to this temperature elevation for uncertain duration, Dietetic Service Managers 1 and 2 stated that all of the ice cream and sherbet stored there as well as what had come from it and stored in the cafeteria servery reach-in freezer had to be discarded. On 6/18/08 at 9-10 a.m. Dietetic Service Manager 2 stated that the main kitchen reach-in freezer was "brand new" and that no directions had been provided upon delivery as to the correct setting of the thermostat. He stated that he suspected that the problem had gone "undetected" because the internal temperature had routinely been checked at 4 a.m. when due to lack of access by dietetic service staff and firm packing, the ice cream and sherbet remained frozen. 4. On 6/17/08 between 8:37 a.m. and 9:14 a.m.	F 456	3. It is the responsibility of the Veterans Home Food Service Department to notify the Plant Operations Department of any new equipment. Installation & operation instructions will be read before attempting installation, adjustment or operation of any new equipment. A mandatory in-service on Space and Equipment was conducted for Food Service and Plant Operations staff on 07/15/08. A Dietetic Service Manager will oversee the monthly kitchen inspection and report variances to the QA Committee.	7/15/08

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F 456	Continued From page 30 in the main kitchen there were inaccurate internal thermometers in refrigerators which had been under regular (non-defrosting) conditions. a. At 8:37 a.m. in a walk-in refrigerator which was designated for dairy foods and had a gauge which registered 39 degrees F, the milk was at 41 degrees F, yet two internal thermometers registered varying temperatures of 36 degrees F and 46 degrees F respectively. At 8:37 a.m. Dietetic Service Manager 2 stated, "Maybe we need some new thermometers." b. At 8:40 a.m. in a reach-in refrigerator in which mandarin oranges were 39 degrees F and shakes were at 44 degrees F, the internal thermometer registered 56 degrees F while the gauge registered 41 degrees F, At 8:40 a.m. Dietetic Service Manager 1 attributed the temperature elevation of the shakes, which should have been maintained at 41 degrees F to ensure safe chilling of it and other potentially hazardous foods, to the exposure to the warm ambient air temperature of the kitchen upon opening the door. She had no explanation as to why the internal thermometer registered a much higher temperature than the foods and gauge. Also, at 8:40 a.m. there was a reach-in refrigerator in which there was only freshly stocked bean salad which had a gauge which registered 31 degrees F while the internal thermometer was at 42 degrees F Additionally, as of 8:49 a,m. there were three empty reach-in refrigerator units readily available for use which had major discrepancies between the gauges and internal thermometers. One had a gauge registering 38 degrees F while the internal thermometer registered 28 degrees F, another	F 456	4 A & B. All internal thermometers were checked for accuracy and replaced on 06/21/08. A mandatory in-service on Space and Equipment was conducted for Food Service and Plant Operations staff on 07/15/08. The Director of Clinical Dietetics and Nutrition Services or designee will perform random checks of the internal thermometers as well as an in depth check of all internal thermometers during the monthly kitchen inspection and report variances to the QA Committee.	7/15/08

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F 456	Continued From page 31 had a gauge which registered 45 degrees F while the internal thermometer registered 50 degrees F and another had a gauge, which registered 33 degrees F while the internal thermometer registered 45 degrees F. By 9 a.m. although Dietetic Service Manager 1 stated that she thought that the unit which had the internal thermometer, which registered 50 degrees F, was the result of it having been "just fixed" (in which the unit may have been off and/or the door opened), there were no explanations as to why the gauges and internal thermometers had discrepancies and in some instances registered temperatures, which were more than 41 degrees F, the minimum for the safe chilling of potentially hazardous foods. 5. On 6/17/08 at 10:03 a.m. in the main kitchen plumbing there were two vacuum breakers designed to prevent sewage backflow, which tops which had broken-off. At 10:03 a.m. Operations Staff 1 stated that while both breakers were operable, the tops needed to be replaced. Cross-Reference to F 371.	F 456	5. The Plant Operations department conducts preventive maintenance by systematically servicing and inspecting the facilities equipment. It is the responsibility of the Food Service department to notify the Plant Operations department of any equipment concerns. The broken vacuum breakers were reported to the Plant Operations staff and repaired on 7/11/08. A mandatory in-service on Space and Equipment was conducted for Food Service and Plant Operations staff on 07/15/08.The Dietetic Service Manager will oversee the reporting of all equipment concerns. The Director of Clinical Dietetics and Nutrition Services will meet with the Dietetic Services Managers to discuss maintenance concerns on a weekly basis and report variances to the QA Committee.	7/15/08
F 465 SS=B	483.70(h) OTHER ENVIRONMENTAL CONDITIONS The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure that it had a safe environment for staff in the main kitchen. By not	F 465	It is the policy of the Veterans Home to provide a safe, functional, sanitary and comfortable environment for residents, staff and public.	

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F 465	Continued From page 32 having a safe environment, there was the potential for injury to dietetic service staff. Findings: 1. On 6/17/08 between 9:14 a.m. and 9:29 a.m. in the main kitchen, there were two pieces of equipment that had not been secured so as to prevent injury. At 9:14 a.m. there was a mobile reach-in refrigerator near the trayline, which had not had the brakes set. At 9-14 a.m. Dietetic Service Manager 1 stated that this had been an oversight and that the "brakes should be set firmly, so that it will not roll." Also, at 9:29 a.m. in the main kitchen there was a manual slicer which was not in use that did not have the sliding portion set securely. At 9:29 a.m. Dietetic Service Manager 1 stated that she would "talk to staff' about this potentially unsafe practice, 2. On 6/17/08 at 9:40 a.m. in a main kitchen aisle near the hot beverage set-up there was a transport cart with a broken handle. At 9:40 a.m. Dietetic Service Manager 1 stated, "it has been like this awhile."	F 465	1. The mobile refrigerator's brake and the manual slicer's sliding portion was secured immediately on 06/17/08. A mandatory in-service on Space and Equipment was conducted for Food Service and Plant Operations staff on 07/15/08. All equipment will be secured immediately after each use. A Dietetic Service Manager or designee shall oversee the procedures to ensure compliance. The Director of Clinical Dietetics and Nutrition Services will perform random checks as well as an in depth monthly kitchen inspection and report variances to the QA Committee. 2. The stained and broken utility carts were disposed of immediately on 6/17/08. A Dietetic Service Manager or designee shall oversee the equipment. The Director of Clinical Dietetics and Nutrition Services will perform random checks as well as an in depth monthly kitchen inspection and report variances to the QA Committee.	7/15/08 6/17/08
F 493 SS=D	483.75(d)(l)-(2) GOVERNING BODY The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility This REQUIREMENT is not met as evidenced			

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F 493	Continued From page 33 by: Based on observation, and interview, the facility failed to ensure the operation of the facility. Findings: 1. On 6/16/08 at 6:30 a.m., during the initial tour of the facility, with the night shift licensed staff, (Unit 700) it was observed that some resident's rooms had a red dot on the nameplate and the background on some nameplates were red, During interview with the tour staff, she said that the red dot indicates a Hospice patient. As the tour progressed, several resident's doors were observed to have a red dot and/or a red background on the nameplate, suggesting a significant number of residents were on Hospice. The licensed tour staff finally said she didn't know what the red dot meant, but she would ask someone. The tour continued with the licensed morning staff who also did not know what the red dot and/or red background on the nameplate meant. A third staff said the red dot was a designation for "Do Not Resuscitate" and the red name plate indicates the resident's physician. On 6/17/08 at 10:45 a.m., a request was made for the "Red Dot" policy and procedure. The Standards Compliance Coordinator said that the Assistant Director of Nursing decided to remove the red dots the previous week, "because the facility was no longer using them. " She further stated, "All were taken down a week ago, except for your unit (referring to Unit 700)." The same day, a policy and procedure was provided for review. Policy and Procedure	F 493	1 & 2. The policy for "Color Coding Resident Medical Status" is no longer in use and had not been for a while. All meaningless red dots remaining on resident doors, identification bands and on resident charts were immediately removed. The charge nurses maintain a list of residents with a DNR status in case of emergency. The red background in the resident nameplate is used to identify the residents' physician, not DNR status. Three background colors are used for our three physicians. This is by physician choice to increase their efficiency while working on the nursing units. This does not indicate any medical condition the resident may have.	6/16/08

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F 493	Continued From page 34 SNS.SNF.056 "Color Coding Resident Medical Status", revised 2/8/05, was reviewed. The policy indicates that the color coding was to identify residents medical conditions. Red indicates DNR (Do Not Resuscitate); Pink indicates Swallowing Precautions and Yellow indicates Diabetes Mellitus. The dots were to be placed on "The residents ID (identification) band, medical record spine, and resident room nameplate." 2. During the initial tour on 6/16/08 at 6:05 a.m., multiple rooms had red dots on the doors where the resident nameplate was posted on Unit 300. An interview was conducted at this time with nursing staff on tour with surveyor, who stated she did not usually work on this unit and she did not know what the red dots represented. An interview was conducted with day nursing staff on 6/16/08 at 7:30 a.m., who stated the red dot meant no DNR (Do not resuscitate). 3. During the initial tour on 6/16/08 at 6:05 a.m., in a room on Pod 600 two e-tanks (Oxygen tanks) were observed laying on the floor. They were not secured. An interview was conducted at this time with the nursing staff member on tour with surveyor, who stated, it is not our policy to have the oxygen in the rooms like this. 4. During the initial tour on 6/16/08 at 6:05 a,m., in a room on Pod 600 a resident was observed with oxygen being administered via nasal cannula. The oxygen tubing was not labeled as to when it was put on.	F 493	3. The e-tanks were immediately placed into a storage rack in the resident's room on 6/16/08. The hospice provider brought in the e-tanks. The hospice nurse was spoken to by our SRN and was counseled by the hospice supervisor. The SRN's checked every residents room that use oxygen to ensure compliance. The charge nurses will monitor all residents using E-tanks during their safety rounds every shift to ensure compliance and will report variances to the QA committee quarterly. 4. The Charge Nurse was counseled for not labeling the tubing after changing it. We will continue to ensure compliance with our oxygen policy and procedures. The SRN's will monitor compliance weekly and report variances to the QA committee quarterly.	6/16/08 6/16/08

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F 493	Continued From page 35 An interview conducted at this time with the nursing staff member on tour with surveyor, stated that it is facility policy to label the oxygen tubing and that it should be changed every 72 hours. The facility policy and procedure for Oxygen Administration was reviewed on 6/19/08. The policy states under Section 1 "General J. oxygen cylinders shall be stored in the oxygen storage area located outside of unit 300 on the east side of Building A. Cylinders shall be standing against the sides of the storage areas and secured in place with safety chains. K. Oxygen storage areas will be locked at all times." The facility policy and procedure for The Environment of Care lists under "Oxygen Equipment 02 masks, cannulas, tubing, and humidifiers labeled and dated every 7 day."	F 493		
F 517 SS=C	483.75(m)(1) DISASTER AND EMERGENCY PREPAREDNESS The facility must have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and document review, the facility failed to ensure that there was a safe supply of emergency/disaster water. By not having this assurance there was the potential for unsafe provision. Finding:	F 517	**Please see Attached Informal Dispute Resolution (IDR).**	

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F 517	Continued From page 36 On 6/17/08 at 10:04 a.m. inspection of the outdoor storage closet containing eight 55 gallon drums of emergency/disaster water dated 2004 revealed that the lids were coated with dust although an internal communication dated 5/6/04 indicated that the drums of water would be "good for 5 years" At 10:25 a.m. review of the emergency/disaster plan for the treatment of contaminated water with Dietetic Service Manager 1 revealed that an unspecified bleach product was to be used in treating water and that it was uncertain if the conditions of the drums might mean that the water had also been contaminated. As the drums were dirty and the bleach product uncertain, there was the potential for an insufficient, safe supply of potable emergency/disaster water.	F 517		